Virginia Department of Medical Assistance Services
Family Planning Services Program
Fact Sheet

Purpose of the Waiver:	• To evaluate the impact of extending Medicaid coverage for family planning services to women who were enrolled in Medicaid due to a pregnancy, who would normally lose Medicaid coverage 60 days post partum. • To evaluate the impact of the waiver on birth outcomes; birth spacing and rates; and costs associated with labor and delivery and newborn/infant care.
Who is Eligible?	Any woman who meets all of the following criteria is eligible for Family Planning Services: • Has received a pregnancy related service paid for by Medicaid during her most recent pregnancy; • Has not had a hysterectomy or tubal ligation; • Is less than 24 months from the end of her pregnancy; • Is not eligible for another Medicaid covered group; • Has income at or below 133% of the federal poverty limit; and • Meets citizenship and residency requirements.
What will this waiver offer?	The Family Planning Services program provides Medicaid coverage for the following services for up to 24 months following the end of the month in which the pregnancy ends: • Family planning office visits which include: o Annual Gynecological exam and Pap screening (one per 12 months); o Sexually transmitted infection (STI) testing (limited to the initial family planning encounter); o Laboratory services for family planning and STI testing; and o Family planning education and counseling; • Food and Drug Administration (FDA) approved contraceptives, including diaphragms, contraceptive injectables, and contraceptive implants; • Over-the-counter contraceptives; and, • Sterilizations (excluding hysterectomies).

Non-Covered Services:	Individuals on the waiver are not eligible to receive other Medicaid services, to include the following: • performance of, counseling for, or recommendations of abortions; • infertility treatments; • performance of a hysterectomy; • transportation to a family planning service; • primary care services; and • any service not related to family planning.
How does a woman apply?	Any woman who received a pregnancy related service paid for by Medicaid may be eligible for enrollment in the Family Planning Services program. • No application is required. • The recipient should contact her Local Department of Social Services to notify her eligibility worker about the end of her pregnancy. If eligible, the worker will enroll the recipient in the Family Planning Services program beginning the first of the month following her 60 day post partum period.
Primary Care Referrals:	• If a Family Planning Service recipient needs services other than those covered through this program, they should be referred to their primary care provider for these services. • If the recipient does not have a primary care provider, the recipient may be referred to a community or rural health clinic that provides care for free or on a sliding fee scale.
Provider Qualifications:	Services must be ordered, prescribed and directed, or performed within the scope of the licensed practitioner. The recipient may access a Medicaid enrolled hospital, physician, nurse practitioner, medical clinic, or pharmacy to receive family planning services.
Quality Assurance:	DMAS shall provide for continuing review and evaluation of the care and services paid through Medicaid including review of utilization of the services by providers and recipients. Providers will be subject to retraction if services provided do not meet the program criteria, if providers failed to maintain records or documentation to support their claims, or if providers billed for medically unnecessary services.